CITY OF BOSTON
COMPARISON OF HEALTH PLAN BENEFITS in effect as of July 1, 2010

The purpose of this benefit comparison is to provide employees with a brief overview of the benefits offered by the City's group health plans. This comparison does not represent complete plan benefits. Each plan's benefits are subject to certain definitions, limitations and exclusions as outlined in the respective plan documents. Should any questions arise concerning benefits, plan documents will govern. For those plans that require members to receive care through a network of health care providers in order to receive benefits, refer to the specific plan brochures for the list of participating providers.

Medical Plan	**Blue Cross Blue Shield Master Medical (See note below)**	**Blue Cross Blue Shield Blue Care Elect Preferred**	**Blue Cross Blue Shield Blue Choice**	**Harvard Pilgrim POS**	**Boston Medical Center Advantage**	**Harvard Pilgrim HMO**	**Neighborhood Health Plan**
Monthly Rates	$318.92 Ind / $739.88 Fam	$253.04 Ind / $587.04 Fam	$181.96 Ind / $469.44 Fam	$133.56 Ind / $359.24 Fam	$93.92 Ind / $252.64 Fam	$93.92 Ind / $252.64 Fam	$90.68 Ind / $240.32 Fam
Deductible *(per calendar year)*	$50 per member or $100 per family - only applies to Extended Benefits	In-Network: None Out-of-Network: $250 per member or $500 per family	In-Network: None Out-of-Network: $50 per member or $100 per family	In-Network: None Out-of-Network: $200 per member or $400 per family	None	None	None
Out of Pocket Maximum	None	In-Network: None Out-of-Network: $1,000 per member or $2,000 per family	$2,450 per member or $4,900 per family, including the deductible, per calendar year.	$1,500 per member or $3,000 per family, excluding the deductible, per calendar year.	$2,000 per member or $4,000 per family annual maximum; Excludes durable medical equipment and prescription drugs.	None	None
Lifetime Maximum Benefit	$250,000 per member for Extended Benefits.	In-Network: None Out-of-Network: None	In-Network: None Out-of-Network: $1,000,000	In-Network: None Out-of-Network: None	None	None	None
Office Visits (Medical/ Mental Health/ Substance Abuse)	80% coverage after deductible	In-Network: $15 per visit Out-of-Network: 80% coverage after deductible	In-Network: $10 per visit ($5 per visit for children under age 12) Out-of-Network: 80% coverage after deductible	In-Network: $10 per visit Out-of-Network: 80% coverage after deductible	BMC Advantage Network: $10 per visit HPHC Provider Network: $20 per visit, referral required	$10 per visit	$10 per visit
Prescription Drugs *(must be purchased from participating pharmacies unless otherwise noted)*	80% coverage not subject to Extended Benefits deductible. Full coverage after reaching coinsurance maximum of $200 per individual or $400 per family. Mail Order: Up to a 90-day supply $5/generic; $10/brand name	In-Network: Up to a 30-day supply at retail pharmacy or 90-day supply mail service $10 – Tier 1 $25 – Tier 2 $45 – Tier 3 Out-of-Network: Not covered. Must use in-network pharmacy through Express Scripts, Inc.	In-Network: Up to a 30-day supply $5/generic; $10/brand name Out-of-Network: Covered at in-network level only for emergencies. Mail Order: Up to a 90-day supply $5/generic; $10/brand name	In-Network: Up to a 30-day supply: $5 - generic $10 – brand/formulary drugs $25 – brand/non-formulary drugs Out-of-Network: $5 - generic $10 – brand/formulary drugs $25 – brand/non-formulary drugs	Up to a 30-day supply: $10 - generic $15 – brand/formulary drugs $30 – brand/non-formulary drugs Mail Order – Up to a 90 day supply: $20 - generic $30 – brand/formulary drugs $90 – brand/non-formulary drugs	Up to a 30-day supply: $5 - generic $10 – brand/formulary drugs $25 – brand/non-formulary drugs Mail Order – Up to a 90 day supply: $10 – generic $20 – brand/formulary $75 – brand/non-formulary	Up to a 30-day supply: $5 - generic $10 – brand/formulary drugs $25 – brand/non-formulary drugs Mail Order – Up to a 90 day supply: $10 – generic $20 – brand/formulary $75 – brand/non-formulary

NOTE: Your union affiliation will determine whether you are eligible to enroll in the Master Medical Plan

Medical Plan	Blue Cross Blue Shield Master Medical	Blue Care Elect Preferred	Blue Choice	Harvard Pilgrim POS	Boston Medical Center Advantage	Harvard Pilgrim HMO	Neighborhood Health Plan
Hospitalization (Medical/ Mental Health/ Substance Abuse)	Covered in full	In-Network: Covered in full Out-of-Network: 80% coverage after deductible. Covered in full for emergency/accident admissions.	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	BMC Advantage Network: Covered in full HPHC Provider Network: Covered in full after a $100 copayment per day up to a maximum copayment of $500 per member per calendar year.	Covered in full	Covered in full
Routine Pediatric Care	80% coverage after deductible, less any inpatient visits used, according to schedule: 6 visits in first year (less any inpatient visits); 3 visits in second year; 1 visit per year age 2 through age 5	In-Network: $15 per visit Out-of-Network: 80% coverage after deductible. Both In & Out-of-Network according to schedule: 10 visits in first year; 3 visits in second year; 1 visit per year age 2-11; 1 visit every 2 years age 12-18 In & Out-of Network combined	In-Network: $5 per visit ($10 per visit for children age 12 and older) Out-of-Network: 80% coverage after deductible according to schedule: 6 visits in first year (less any inpatient visits); 3 visits in second year; 1 visit per year age 2 through age 5.	In-Network: $10 per visit Out-of-Network: 80% coverage after deductible according to schedule: 6 visits in first year; 3 visits in second year; 1 visit per year age 2 through age 6.	BMC Advantage Network: $10 per visit HPHC Provider Network: Not covered	$10 per visit	$10 per visit
Adult Physicals	Not covered	In-Network: $15 per visit Out-of-Network: 80% coverage after deductible. Both In & Out-of-Network according to schedule: 1 visit/5 yrs age 19-29; 1 visit/3 yrs age 30-39; 1 visit/2 yrs age 40-54 1 visit per yr age 55+ In & Out-of Network combined	In-Network: $10 per visit Out-of-Network: Not covered	In-Network: $10 per visit Out-of-Network: 80% coverage after deductible	BMC Advantage Network: $10 per visit HPHC Provider Network: Not Covered	$10 per visit	$10 per visit
Emergency Room	Covered in full for hospital charges and physician services in emergency room	In-Network: $50 per visit Out-of-Network: $50 per visit	In-Network: $25 per visit Out-of-Network: $25 per visit for approved emergency care; Otherwise, 80% coverage after deductible.	In-Network: $30 per visit Out-of-Network: $30 per visit for treatment of life-threatening illness or injury; 80% coverage after deductible for other care.	BMC Advantage Network: $40 per visit HPHC Provider Network: $40 per visit	$30 per visit	$25 per visit
Ambulance Services	80% coverage after deductible	In-Network: Covered in full Out-of-Network: Covered in full for accident or emergency;80% coverage after deductible for other medically necessary transport	In-Network: Covered in full Out-of-Network: Covered in full for emergency transport; 80% coverage after deductible for other medically necessary transport	In-Network: Covered in full Out-of-Network: Covered in full	BMC Advantage Network: Covered in full HPHC Provider Network: Covered in full	Covered in full	Covered in full
X-Ray and Lab	Covered in full	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	BMC Advantage Network: Covered in full HPHC Provider Network: Covered in full	Covered in full	Included in office visit
Chiropractic Care	80% coverage after deductible	In-Network: $15 per visit Out-of-Network: 80% coverage after deductible	In-Network: Not covered Out-of-Network: 80% coverage after deductible	In-Network: Not covered Out-of-Network: 80% coverage after deductible	$10 per visit for up to $1,000 per member per calendar year for covered services received from a participating chiropractor.	Not covered	Not covered

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Durable Medical Equipment	80% coverage after deductible	In-Network: Covered in full for up to $1,500 per member per calendar year. Out-of-Network: 80% coverage after deductible for up to $1,500 per member per calendar year. In & Out-of-Network maximum combined	In-Network: 80% coverage for up to $1,500 per member per calendar year. Out-of-Network: 80% coverage after deductible for up to $1,500 per member per calendar year.	In-Network: Same as Harvard Pilgrim HMO benefit Out-of-Network: 80% coverage after deductible.	BMC Advantage Network and HPHC Provider Network: Covered in full after a copayment of 20%, not to exceed a member's total expense of $1,000, up to a combined benefit maximum (both networks) of $5,000 per calendar year, including member copayment.	Covered in full up to $2,500 per calendar year.	Covered in full up to $2,500 per calendar year
Home Health Care	Covered in full	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	BMC Advantage Network: Covered in full HPHC Provider Network: Covered in full	Covered in full	Covered in full
Physical Therapy	80% coverage after deductible for physical therapists' services in the office. Covered in full for services provided in a hospital outpatient department.	In-Network: $15 per visit Out-of-Network: 80% coverage after deductible In & Out-of-Network maximum combined benefit of 100 visits per calendar yr	In-Network: $10 per visit ($5 for children under age 12) for up to 90 consecutive days per condition. Out-of-Network: 80% coverage after deductible	In-Network: Same as Harvard Pilgrim HMO benefit Out-of-Network: 80% coverage after deductible.	BMC Advantage Network: $10 per visit for up to 90 consecutive days per condition. HPHC Provider Network: $20 per visit for up to 90 consecutive days per condition.	$10 per visit for up to 60 consecutive days per condition.	Covered in full for up to 90 consecutive days
Vision Care	No coverage for routine care. Discounts on eyeglasses and contact lenses from participating providers.	In-Network: $15 per visit Out-of-Network: 80% coverage after deductible. 1 visit per 24 months; In &Out-of-Network combined.	In-Network: One routine vision exam per calendar year at $10 per visit ($5 per visit for children under 12). Out-of-Network: No coverage for routine care. Discounts on eyeglasses and contact lenses from participating providers.	In-Network: $10 per visit Out-of-Network: 80% coverage after deductible Discount on eyewear from participating providers.	BMC Advantage Network: Annual eye exam at $10 per visit. HPHC Provider Network: Annual eye exam at $20 per visit. Discount on eyewear from participating providers.	Annual eye exam at $10 per visit	$10 per visit for annual routine eye exam
Dental Care	Not covered	Not covered	In-Network: Preventive dental care for children under age 12. Out-of-Network: Not covered	In-Network: Same as Harvard Pilgrim HMO benefit Out-of-Network: Not covered	None	2 preventive dental exams per calendar year, for adults and children. Thru age 12: No charge Age 12 & up: $10/visit	One preventive dental care visit every six months for children under age 12. No co-payment..